How to Report Medicare or Medicaid Fraud or Abuse

Key Players in Fraud Investigations – Who does what?

1) The U.S. Department of Health and Human Services (HHS) is the principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves through Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people). Among the key divisions or agencies are the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG).

HHS plays a critical role in ensuring that beneficiaries and taxpayers get their money's worth from the Medicare program and works closely with OIG, other law enforcement agencies and CMS to investigate and enforce the laws to protect beneficiaries and taxpayers. HHS also helps providers to file Medicare claims correctly, and educates doctors and health care providers to understand and follow Medicare law and regulations.

HHS is working to simplify requirements to further reduce payment errors and oversees claims payments to stem fraud, waste and abuse. These efforts are showing significant results. Medicare's estimated error rate has fallen by more than half, from 14% in fiscal year 1996 to 6.3% in fiscal year 2001, according to annual independent reviews conducted by the HHS Office of Inspector General (OIG). The error rate measures payments made by Medicare which are not properly supported by health care providers' documentation or which otherwise do not meet Medicare reimbursement requirements.

In cases where evidence suggests fraudulent billing practices, HHS works closely with the OIG, other law enforcement agencies, and CMS to investigate and enforce the laws. Health care providers are not subject to civil or criminal penalties for innocent errors, as the laws only cover offenses involving actual knowledge, reckless disregard or deliberate ignorance of the falsity of claims. In fiscal year 2001, the federal government recovered more than $1.3 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. More than $1 billion was returned to the Medicare Trust Fund.

Although Medicare pays virtually all claims based on the information submitted by providers, payments are considered "improper" if they lack sufficient documentation, if the service provided is found to have been unnecessary, or if the service is coded incorrectly by a physician or other health care provider. Note that Medicare's "improper payment" estimate is not a measure of fraud, although it may include fraud.

2) The Centers for Medicare and Medicaid Services (CMS) is the HHS agency that administers both the Medicare and Medicaid Programs. As steward of the Medicare program, CMS is responsible for: 1) ensuring that Medicare pays correctly for covered services and 2) for implementing the coverage and reimbursement policies that Congress establishes by law.

CMS is also working to improve the quality of the customer service that Medicare contractors provide to physicians and other health care providers. CMS has developed performance standards, quality call-monitoring procedures, and contractor guidelines to make the expectations of the agency clear and to ensure that contractors are reaching those expectations. HHS is committed to taking steps to make Medicare more understandable and user-friendly to help physicians and other providers avoid unintended errors.

3) The U.S. Department of Justice (DOJ), headed by the Attorney General, was established in 1870 (28 U.S.C. 501, 503). Among its 39 separate components are the U.S. Attorneys who prosecute offenders and represent the United States Government in court, the Federal Bureau of Investigation (FBI), one of its major investigative agencies, and the OIG.

4) The Federal Bureau of Investigation (FBI) is the principal investigative arm of the DOJ, with authority and responsibility to investigate all fraud committed against the U.S. government. The FBI's authority to investigate health care fraud extends beyond specified federal programs such as Medicare and Medicaid to include all victims of the crime, whether government programs or private insurance companies, business entities or individuals.

The FBI also is authorized to provide other law enforcement agencies with cooperative services, such as fingerprint identification, laboratory examinations, and police training. However, the FBI does not give opinions

or decide if an individual will be prosecuted. The federal prosecutors employed by the DOJ or the U.S. Attorneys offices are responsible for making these decisions and for prosecuting cases.

The FBI's Health Care Fraud Unit was established in 1992 as a separate unit within the Financial Crimes Section of the Criminal Investigative Division. One of its primary missions is to ensure the success of investigations that have a national impact on the health care fraud crime problem. To this end, they concentrate their investigative resources on multi-district investigations of large health care corporations suspected of committing fraud against both public and private payers of health care benefits, and they coordinate these investigations with other law enforcement and regulatory agencies.

No investigations are actually conducted by the Health Care Fraud Unit. The Unit's primary function is to support and provide guidance to their field offices, which can be contacted by phone. Anyone with information on health care fraud is encouraged to call the local FBI field office and ask to speak with the Health Care Fraud Supervisor. **The number to call in Arkansas is 501.228.8517. Anyone with information on health care fraud, waste or abuse may also call the HHS-OIG hotline, 1-800-HHS-TIPS.**

Many of the FBI's 56 field offices rank health care fraud as their number one white-collar crime problem. Health care fraud offenses are being investigated in every one of the FBI's field offices and many of the larger offices have squads of agents whose sole responsibility is to investigate health care fraud.

Due, in large part, to the funding received as a result of the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the FBI has been able to increase the number of agents assigned to health care fraud. Between 1992 and 1999, the number of active health care fraud investigations increased from 592 to over 3,000. Convictions for health care related offenses increased from 116 to 548.

In addition to traditional criminal investigations, the FBI has become increasingly involved in the investigation of Qui Tams, or civil false claim lawsuits, filed under seal by individuals, referred to as relators, who allege fraud against the United States. The successful investigation of these

cases, by the FBI and other agencies, has returned hundreds of millions of dollars to the Medicare Trust Fund.

Several recent case summaries illustrate the diversity of FBI joint investigations with other agencies:

Case #1: An approximately five-year investigation of the largest certified home health agency (HHA) in Miami resulted in the conviction of 20 individuals for their involvement in a massive and sophisticated scheme to defraud Medicare. **The home health agency was paid approximately $120 million in Medicare funds for nursing and home health aide services that had not been provided, were not necessary, or were provided to persons who were either not eligible or deceased.** The two highest-level agency administrators admitted to illegal hidden partnerships in hundreds of subcontractor groups and involvement in hundreds of thousands of dollars of illegal payments to numerous individuals from "professional beneficiaries," to home health aides, nurses, and doctors. The convicted defendants received sentences ranging from 18 months imprisonment to, in the case of the highest-level administrator, 12 years imprisonment. A single defendant returned $1.1 million in fraudulently obtained assets.

Case #2: Recently, Fresenius Medical Care North America, Inc., the world's largest provider of kidney dialysis products and services, agreed to pay the United States government $486 million to resolve a sweeping investigation of health care fraud by its kidney dialysis subsidiary. A three-count indictment charged conspiracy to defraud the United States by obtaining payment of false or fraudulent claims, and a total criminal fine of $101 million and a civil settlement of $385 million was recovered – the largest civil fraud recovery in history. The criminal violations related to the submission of claims for medically unnecessary tests and the payment of kickbacks for referrals.

Case #3: In another case, Beverly Enterprises of California (BEC), a subsidiary of Beverly Enterprises, Inc. (Beverly), pled guilty to criminal mail fraud and making false statements to Medicare. Beverly was assessed a $5 million criminal fine, will pay the government $170 million, and will divest selected Beverly nursing homes. Beverly was required to pay $25 million

within 30 days with the remaining $145 million payable over an eight-year period.

5) The Department of Justice (DOJ)

6) Medicaid Fraud Control Units (MFCUs) are federally funded state law enforcement entities that investigate and prosecute Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. They also review complaints of patient abuse and neglect and of misappropriation of patient funds in all residential healthcare facilities that receive Medicaid funds. If appropriate, they also investigate and prosecute the people responsible.

MFCUs are staffed by attorneys, investigators and auditors trained in the complex litigation aspects of healthcare fraud and patient abuse and neglect. They are required to be separate and distinct from the state Medicaid program and are usually located in the state attorney general's office.

6) THE PRIVATE SECTOR – This means YOU! What do your do? Who do you call?

- **First, call the provider with your concerns.**

  If the Medicare beneficiary has a question about the services on a Medicare Summary Notice (MSN) or Explanation of Medicare Benefits (EOMB), he/she should call the provider's office first to request an explanation of the service(s) in question. If the beneficiary is uncomfortable calling the provider, a family member or even one of the Senior Medicare/Medicaid Patrol volunteers could assist in the call.

- **Second, call the Medicare contractor noted on the Medicare Statement.**

If the beneficiary does not wish to call the provider or there are still concerns after calling the provider, call the Medicare contractor listed on the MSN.

- **If you have a concern regarding suspected provider fraud where the service is paid for by Medicaid, such as Personal Care, Nursing Home or Prescription Drugs, contact the Attorney General's Medicaid Fraud Control Unit at 1-866-810-0016.**
- **If you have a concern regarding suspected Medicaid recipient fraud, contact the Department of Health and Human Services Hotline for Medicaid Fraud & Abuse at 1-800-422-6641.**
- **If the matter is still not resolved, call the toll-free Senior Medicare/Medicaid Patrol Fraud Hotline at 1-866-726-2916.**

In all of the above cases, when you make the call, have the MSN in front of you, as well as the following information:

- The beneficiary's Medicare Health Insurance Claim Number or Medicaid Number,
- The name of the provider and any identifying number you might have,
- The item or service you are questioning,
- The date of service
- The amount approved and paid by Medicare or Medicaid.
- The date on the explanation of benefits (EOMB or MSN).
- A description of the problem or reason why you believe that Medicare or Medicaid should not have paid (**For example**, my MSN shows that Medicare paid for a visit to Dr. Feelgood on June 10 for an extended office visit, but I was in the hospital on that date).

If you plan to write rather than call, clearly state at the beginning of your letter that you are filing a fraud complaint. This will help to ensure that your complaint is forwarded to the fraud unit.

Beneficiaries are encouraged to keep a record of appointments and brief descriptions of services provided, along with all of their MSNs in one location. This will make it easier to retrieve needed dates, papers, etc.

Remember to tell the Medicare or Medicaid office that you are calling to make a fraud report so that your call will get the proper attention.

Sometimes callers must wait on the phone for a long time to speak to a human being to make a report, as they must wait for the next available person. Please ask beneficiaries to record their experience when they called in their report – what number was called and approximately how long they had to wait to speak to someone. Such delays are a deterrent to reporting and, if this proves to be a problem, we will want to report it to the proper agencies. Volunteers should make a written record of this problem when they complete the reporting forms or if no complaint is filed by the volunteers, a separate written note should be recorded so that is can be easily retrieved and included in the monthly reporting of activities.

We do not anticipate delays in answering the toll-free Senior Medicare/Medicaid Patrol Hotline, so beneficiaries should be advised to contact us with their report, if they cannot get through to another agency. We will make sure all complaints are reported to the proper agency and will complete written referrals.

All callers to the Senior Medicare/Medicaid Patrol Hotline that indicate that the call is about Medicaid provider fraud will be immediately and seamlessly transferred to the Medicaid Fraud Control Unit (MFCU) in the office of the Arkansas Attorney General.

Numbers to Call:

Arkansas Senior Medicare/Medicaid Fraud Patrol
Toll free Hotline: 1-866-726-2916

To report Medicare fraud – Medicare Hotlines: Part A 1-877-356-2368
Part B 1-800-482-5525
For Both A & B, TDD. 1-888-476-3009

Arkansas Blue Cross Blue Shield
Attention: George Karpoff
6th and Gaines
Little Rock, AR 72201

To report Medicaid provider fraud. – Medicaid Fraud Hotline: 1-866-810-0016
Medicaid Fraud Control Unit
Office of the Attorney General
323 Catlett-Prien Tower
Little Rock, AR 72201-2610
(501) 682-7760
fax: (501) 682-8135

To report Medicaid recipient fraud – DHHS Fraud & Abuse Hotline: 1-800-422-6641

U.S. Office of the Inspector General
HHS TIPS Fraud Hotline: 1-800-HHS-TIPS (1-800-477-8477)
Fax: 1-800-223-8164

When a Volunteer Takes a Report of Fraud:

If a volunteer takes a report of fraud that the beneficiary does not call in to one of the listed numbers, the Reporting Form included in this manual should be completed and forwarded to the Arkansas Blue Cross & Blue shield Fraud Unit at the following address:

George Karpoff, Fraud Unit
ABCBS
6th & Gaines
Little Rock, AR 72201

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or

private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

REMEMBER THAT THE STRONGEST WEAPON AGAINST HEALTH CARE FRAUD IS THE BENEFICIARY!